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Original Communications.

A CONTRIBUTION TO THE TREATMENT OF RETROVERSION OF THE UTERUS.

By EPHRAIM CUTTER, M.D., Boston.

FOR a period of more than two years, a case of retroversion of the uterus annoyed me exceedingly. The patient was a married lady, about 40 years of age, native of Maine, mother of seven children, and occupying a position in the middle class of society. She complained of disturbance of the nervous system—sometimes approaching insanity. There were great prostration, irritability and uneasiness; at times, numbness of the extremities and limbs; bearing-down pains in the back; dysmenorrhœa; inability to walk, to lift weights, and to go up stairs without increasing the difficulty.

A physical examination, obtained after much urging and delay, showed the uterus to be completely retroverted. A Simpson's sound could be introduced into the womb completely only when its concavity looked backward and the handle was brought forward towards the pubis. The length of the uterus was normal. The os was rather rugose and patulous. There was no flexion. The treatment consisted in replacing the womb with the sound, and in endeavoring to keep it *in situ* by pessaries of various shapes and materials, which were changed as often as they failed. When I had exhausted all the resources that I was acquainted with, and when the patient was just on the point of giving up all treatment in sorrow and despair, a contrivance was hit upon, which is here exhibited, and which has kept the uterus in place ever since, with exceptions which will be mentioned. The success in this and other cases induces the writer to bring the instrument forward to notice, in the hope that it may prove as efficient in other hands.

The principle of pessaries in uterine displacements has long been announced (Anatomical plates by Jones, Quain, and E. J. Wilson, edited by J. Pancoast, Philadelphia, 1843, Part, The Viscera, p. 55, note) to be an extension of the vagina in its long axis, by restoring the tone and tension of the tube transversely, to prevent the uterus from falling down. It is not part of the principle to distend the vagina transversely, as is done by most internal pessaries. This distention rather weakens the tone of the vagina, by putting it constantly on the stretch. Indeed, in the case of retroversion quoted, the indications of treatment were—

1st, To replace the womb by the sound. This was done by putting the patient on her hands and knees, the head depressed and the hips elevated; then, introducing the sound, concavity backward, to move the handle backward, at the same time rotating it upon its long axis until the concavity looked forward, and the longitudinal axis of the sound corresponded with that of the vagina.

2d, To keep the uterus *in situ naturali* by introducing the pessary shown in Fig. 1 (next page), which, by its peculiar form, extends the vagina in the direction of its long axis, without distending in the direction of its transverse axis, and also without resting upon any point within the vagina, but upon an elastic support, thus imitating the natural guys of the uterus.

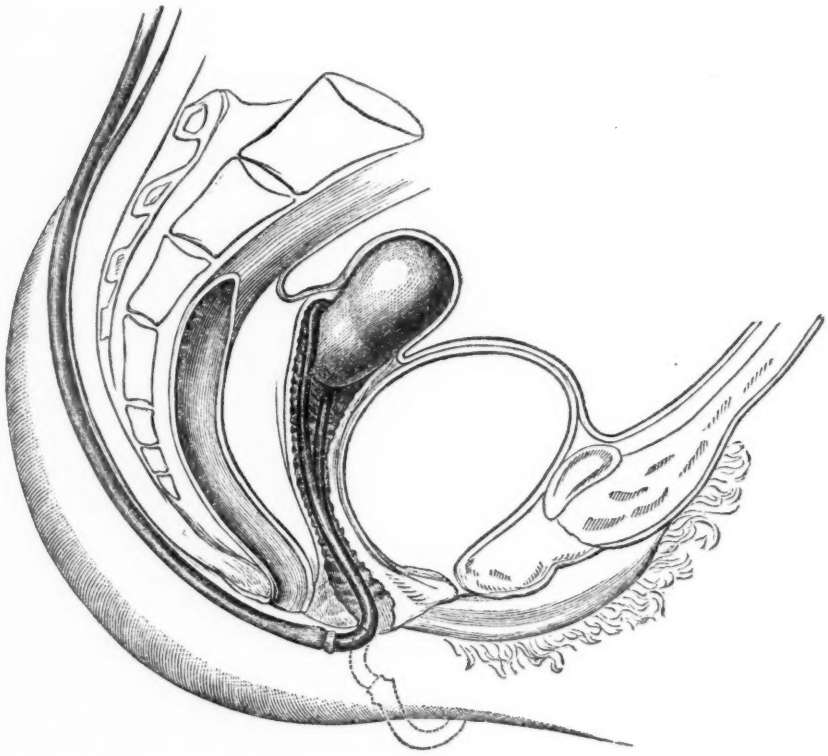
This pessary is made of hard rubber, curved antero-posteriorly, to correspond with the curved axis of the vagina. The uterine extremity is a loop, bent backward just enough to receive the convexity of the posterior surface of the neck of the womb, and accurately fit the posterior vaginal cul de sac. Towards the other end of the pessary, the sides of the loop become fused into one piece, which extends out of the vulva and bends directly backwards into a hook, thus embracing the posterior fourchette and the perinæum. To the free extremity of the hook is attached a piece of India-rubber tubing, about six inches in length and one quarter of an inch in diameter. This tubing lies in the furrow between the buttocks, and is provided at its free extremity with a loop, to which is attached either a tape or band, which surrounds the

pelvis of the patient and completes the apparatus. The features peculiar to myself are:

The single posterior support of an elastic India-rubber tube, the hooked termination, and the full antero-posterior curve.

The remaining features of this pessary have been made known to the profession by Professor Storer, Jr., introduced by him from London. This pessary is supported by two parallel bands extending from the pubis in front to the sacrum behind. Thus this pessary has two points of support. My modification consists essentially in reducing the points of support to *one* only, and that *from behind solely*.

FIGURE 1.



Section of female pelvis. Beginning on the right hand, we have the mons veneris, the os pubis, the urinary bladder, the uterus (side view), the vagina contracted about the pessary, the rectum, the sacrum, the natal furrow, the posterior suspensory tubing, the right buttock.

The pessary is seen behind the neck of the womb, in the posterior vaginal cul de sac. It extends in the direction of the longitudinal axis of the vagina. At the posterior fourchette it takes a short turn backward, and is attached to India-rubber tubing which lies in the natal furrow, and is fastened to the pelvic belt, which is not represented in the cut. At the posterior fourchette is seen a joint, and the dotted lines represent the hamular process and the tubing turned forward on the joint, to escape the anus during defæcation.

The advantage of the modification will be apparent when it is considered that the apparatus is simple, and that when once introduced and properly fitted, it cannot easily become deranged. The furrow between the buttocks prevents the lateral motion of the tube of support. The attachment to the pelvic band prevents all downward displacement, except that which is immediately restored by the contractility of the suspending medium. The only point of pressure contact within the vagina being at the posterior vaginal cul de sac, the concave surface of the smooth hamular process fits the perinæum without chafing, and the hook simply lies in the vaginal orifice. If it presses upon the posterior fourchette so as to imbed itself, the instrument is not a fit, and the suspending cord should be loosed or a new instrument procured. If it impinges too forcibly upon the urethra, the cord should be tightened. When properly adjusted, the pessary cannot tip backward, as it will come in contact with the promontory of the sacrum. It cannot go forwards, as it is held by the uterus. Indeed, with-

out being rigid and vice-like, it holds the vagina in its natural axis and curve, and (another most important feature) allows of the normal contraction of the transverse fibres of the vagina. The single attachment of the support behind enables the patient to micturite without disturbing the apparatus, which cannot be done with the double attachment. When it is remembered that frequent micturition is an almost constant accompaniment of uterine disease, performed very much oftener than the function of defæcation—this posterior suspension acquires an increased importance.

Furthermore, the point of suspension is on a good foundation. The posterior surface of the pelvis, made of bone superficially covered with integument, is smooth and fixed. It is not like the changeable surface of the anterior portion of the abdominal trunk, which is made up mainly of soft tissues on a base of yielding intestines that have a peristaltic motion, besides a continual change of contents in character, quantity and quality. Whenever the supporter does move, it is downward, away from the perinæum.

During defæcation, the pelvic tape is untied, the India-rubber tubing is brought forward between the thighs in front, and the pessary also is brought forward so as to clear the anus, and is held by the hand. It should be held firmly, as the bearing-down efforts sometimes tip the uterus over again, as was done twice in the case related—only twice in eight weeks.

Since the above was written, influenced by the fact of displacement occurring occasionally during defæcation, and also by the opinion of a distinguished specialist that this disadvantage operated against the perfect working of the instrument, I contrived a joint in the hook, in such a manner as to allow the extremity to rotate in a circle, the circumference of which is described by the end of the hook, and the centre of which is the axis of the middle of the hook. The joint is so compact as to present no re-entering angle into which the tissues may be buried or caught, and yet at the same time admits of an easy movement. The *modus operandi* of this joint is simply this. The pelvic band may be loosed, not withdrawn. The hook, with the attached rubber tube, is drawn forward either half or a quarter of a circle, and held there until the act of defæcation is accomplished. It will be seen (Fig. 1, dotted lines) that when the hook is turned forward the length of the pessary is increased by the length of the rotating portion of the hook. The centre of the joint being at the posterior fourchette, the extremity will come in the neighborhood of the pubis, and will be far enough removed from the anus to be out of the way. At the same time, it affords a handle which is easily held.

This joint modification has worked very well practically. Indeed, in the case adduced, the uterus has kept its place since the modified instrument has been employed. At the suggestion of another medical friend (*ut supra*), I have also adopted, in place of the pelvic tape, a broad band of webbing, fastened with a buckle in front. This completes the instrument, and also is preferred by patients. There are three sizes of instruments—4½ inches, 5 inches, and 6 inches in length, the curves and length being graduated to different-sized and shaped vaginæ.

The period of time they can be worn is a matter to be decided by experience. The present patient has worn them for more than nine months. The effect of the instruments has been to restore normal nerve-sensations, to give vigor and strength, so that the patient can engage in heavy housework, and maintain her position as the mother of the family. She refuses to go without the pessary. I have encouraged her in this idea, as the long time in which the uterus had lain retroverted seemed to have essentially impaired the tonicity of the transverse vaginal fibres.

A second case in which this pessary was used was a bed-ridden one, in which retroversion had probably existed for fifteen years continuously, inducing nervous symptoms of a peculiar character, especially an inability to hold the head upright when siting or standing, and an exceedingly irritable condition of the sympathetic nervous system. During the treatment, an obovoid body, of a dirty-green hue, made up of concentric laminæ of a somewhat tough consistence, about an inch and a half in length and half an inch in width, was discharged from the uterus. Since the pessary described has been used, and *during* its use, the retroverted organ has been easily and perfectly maintained in its natural position. The re-placement, however, did not relieve the patient, and the case still remains an *opprobrium medicorum*.

Case III.—Mrs. T. M., born in Ireland, 20 years of age, nervous temperament, with no previous births or miscarriages, was delivered, April 29th, 1867, of a female child, well formed, and weighing 7 pounds. The waters were broken artificially, and there was some forcible dilatation of the os uteri. The child subsequently sickened

and died, at the age of two months, afflicted with an eczematous eruption which covered the whole body, and which was suspected to be specific. During the fall months of the present year, my attention was called to Mrs. M. She was complaining of symptoms that I thought justified a diagnosis of mild typhoid fever. She was treated accordingly, without being confined to her bed, and she afterwards resumed full duties in keeping her house. One day, while at work, she felt a pain in her back, and fell insensible. It appeared that the time had come for a full and thorough examination of the case. It was found impossible to introduce the uterine sound any other way than with the convexity backward. The length of the uterine cavity was normal. The uterus was felt between the sound and the finger. The patient was put on her hands and knees, hips up, and the uterus replaced by means of the sound. A pessary of the smallest size was then introduced, the distal-looped extremity put into the posterior vaginal cul de sac, the pelvic band secured, and the patient resumed the vertical position. About three weeks afterwards (the patient being kept under notice, and the uterus examined at intervals of three or four days with the sound, so as to be sure of its being in place), the family moved to another residence, the patient doing the cleaning-up work and a good deal of the lifting. On visiting her in her new home, I found the pessary had come out from the vagina, although the pelvic band had not been removed, but had become loosed. Her version of the affair was a humorous one. She stated that the premises were infested with rats, and that they invaded the bed-room during the night, and frightened her exceedingly. On awaking in the morning, she felt a cold touch on her person. Supposing it to be one of the vermin in the bed, she made those motions and demonstrations which would be natural to a female in similar circumstances, and discovered the object of her terror to be—her pessary! When I came in, she was on her knees, scrubbing a very dirty floor, the legacy of a former tenant, and after her recital, although she said she had not felt so well for a long time, I supposed of course that the uterus was misplaced again by her unusual exertions. The sound, however, showed it to be *in situ naturali*, and the case was left without the supporter—to be watched.

In this instance, the short duration of the displacement had not destroyed the vaginal tonicity, and the successful employment of the instrument seems to indicate that if these retroversions are detected early and the supporter timely used, the results of this method of treatment may be as satisfactory as other methods have hitherto been unsatisfactory.

Case IV.—Mrs. B., native of New England, bilious temperament, married lady, 28 years of age; mother of one child, 7 years of age. Mostly engaged in household work. Since her child was born, if not before, she has been troubled with nervous symptoms, with numbness of limbs, headache, frequent micturition, bearing-down pains in back, peculiar feelings in the abdomen, especially when pressed upon, inability to endure fatigue or prolonged exertions—pastimes becoming burdens—&c. On examination, the lateral diameter of the vagina was found greater than the longitudinal. The finger came directly in contact with the posterior surface of the uterus. It could be passed behind the fundus. There was no posterior vaginal cul de sac. The same features were presented by a rectal examination. While endeavoring to pass in the sound, the uterus would rise in the pelvic cavity, preserving the horizontality of the longitudinal axis, and the vagina would become enormously distended into a cavity in which the finger could move without obstruction—the walls being smooth and tense, as if stretched out like a tent. This occurred especially when the patient was put upon her hands and knees. The uterus would be so lifted out of reach as to oblige the patient to lie upon the side again before the sound could be introduced. The uterine cavity was three inches in length; the sound moved freely within it. The os was congested. The uterus being replaced by the sound, and the sound withdrawn before the supporter could be put in place, the uterus would slip back. By retaining the sound within the uterus, and passing in the pessary by its side, I was enabled to introduce the instrument properly. On subsequent visits, the pessary was found to be well borne, and the patient was feeling better. Still, it was mortifying to find the uterus balanced by its middle over the end of the pessary, as it were, like a saddle over a horse's back. There being absolutely no posterior vaginal cul de sac as ordinarily found here, it is a case which does not present the feature which is indispensable to the instrument. However, to meet the indications in this, I contrived an intra-uterine pessary, which has the same principle of external support as the one just described. This is represented in Fig. 2. Except during a

menstrual period, this has been well borne. It is to be distinctly understood, however, that the pessary here brought forward is introduced for no other displacement than retroversion. I have but little experience in its use in other displacements, and do not particularly recommend it for them. However, in Fig. 3 is represented a pessary for prolapsus, which embraces the principles of the retroversion pessary modified.

Fig. 2.

Fig. 3.

Intra-uterine pessary on a posterior elastic external suspension.

The pelvic band, the India-rubber tube, the jointed hook are the same, but the ring and the single columnar support constitute the modifications. It is not recommended, but suggested, as I have not had a suitable opportunity for its trial.

Both these pessaries can be obtained of Codman & Shurtleff, 13 and 15 Tremont St., Boston. They are made under the supervision of the writer, and are reliable in workmanship and material.

In conclusion, the writer admits that *all* pessaries are an evil; but how can mechanical supports be dispensed with in relieving such a purely mechanical displacement as retroversion of the womb?

December, 1867.

RUPTURE OF THE SCLEROTIC;

With a Case in which the Lens and the whole of the Iris escaped through the wound, yet the Patient retained Vision of one third, with an appropriate Glass.

Read before the Boston Society for Medical Observation, by O. F. Wadsworth, M.D.

Rupture of the sclerotic is placed by writers on ophthalmology among the most fatal in its effects upon vision of the accidents to which the eye is exposed, and this estimate of the severity of the injury is certainly not exaggerated. Though loss of the organ may not be the result, the usual position of the wound must necessarily entail grave lesions.

Unless the blow be inflicted by a sharp body, or one moving with considerable force and rapidity, in which case the part injured is that directly impinged upon, the wound is caused by the *contre-coup*, and is generally at the inner and upper side, and between the insertion of the recti muscles and the cornea, while at the same time it follows more or less exactly the curve of the latter. The anatomical peculiarities of the orbit, and of the sclerotic itselfand its appendages, and in this connection the tendons of the muscles may be considered as such, seem to be amply sufficient to account for the general situation and direction of the wound. That the blow generally comes from the outer side, or from below, is accounted for by the protection afforded in other directions by the projection of the eyebrow and nose. The sclerotic, thickest posteriorly, gradually thins as it comes forward, is thinnest near its equator, and is strengthened anteriorly by the insertion of the recti tendons and their expansion, and the tarso-orbital ligament. This thinning behind the insertion of the tendons is, however, more than made good by the support which it there receives from the tendons and the capsule of Tenon, and the mass of fat and cellular tissue which fills the orbit, and in which the globe lies, must also have a protecting influence on the posterior parts of the scelerotic. The direction of its fibres, which chiefly, and especially in its anterior part, are nearly concentric to the circumference of the cornea, seems to determine the direction of the wound. According to Lawson, the sclerotic may also be ruptured by a blow falling upon the cornea, which, being a segment of a smaller sphere, acts like a wedge, and from its great elasticity may itself escape injury.

This situation of the wound, directly over the attachment of the iris, ciliary processes, and lens, must, almost without possible exception, cause laceration and prolapse of the iris, and, generally, laceration of the ciliary processes, and of the suspensory ligament of the lens, with dislocation of the latter, and if not immediate rupture of its capsule, later changes in its substance. Not infrequently the lens, as well as a portion of the iris, is forced out through the wound, and if, as sometimes happens, its capsule, and the conjunctiva above the wound, be not ruptured, may for a long time present the appearance of a subconjunctival cystic tumor. Always there is

hæmorrhage into the anterior chamber. Besides these lesions, in a majority of cases there is loss of more or less vitreous, and frequently rupture and separation of the retina and choroid, with hæmorrhage into the posterior part of the eye.

The whole amount of the injury received can, however, not be determined at first; the blood in the anterior chamber prevents the view of the interior of the globe, and it is only after its absorption that the deeper parts can in any case be seen. Though the retina and choroid be uninjured, inflammatory changes in the anterior part of the eye often interfere with the inspection of the fundus even at a later period, and if these structures are also implicated, the probability of ever determining the whole extent of the injury, except after removal of the eye, is naturally much less. Shrinking or suppuration of the globe, and sympathetic ophthalmia, are frequent sequelæ of the injury. By no means in all cases, however, is the final result so fatal; many cases occur where much useful vision is preserved, and a few even retain sufficient for reading ordinary print.

The treatment of this injury is sufficiently simple. Any portion of iris or vitreous protruding through the lips of the wound and preventing its closure should be removed with scissors, whether underneath the unbroken conjunctiva or not, and in the rare cases where the lens remains beneath the conjunctiva it too should be removed. Rest, preferably in a horizontal position; the local application of a solution of atropia or of aqueous extract of opium, and thin folds of linen wet with cool water; anodynes internally for relief of pain, are in general all that is required. In some cases slight compression by lint and bandage is of value. If the loss of vitreous, the extent of the laceration, or the evident injury of the internal parts, be so great as to preclude all hope of saving the eye, enucleation should be at once performed, in order to save the patient from the long and painful process of suppuration or shrinking of the globe, and the danger of sympathetic ophthalmia.

While rupture of the sclerotic is generally so destructive in its effects, the following case is of interest, as showing an amount of immunity from damage to the retina and choroid, and of reparative power in the eye, apparently incompatible with the injury done to the organ.

Patrick Curran, a laborer, aged 62; was born in Ireland, but has lived in this country for 16 years. His health, except for occasional bronchitis the last few winters, has, he states, always been very good, and he appears to be an active man for his age. He came to me last summer at the Dispensary on account of his eyes, and I then fitted him with a glass for his right eye, which he has worn since. Recently I have seen him again and taken the history of his case more fully.

Thirty-five years ago, while working in a quarry in England, a piece of iron struck his left eye, producing immediate loss of sight. Two or three days after he could distinguish shadows with this eye, but did not notice much further improvement until his right eye was injured, now nearly four years ago.

At that time, while feeding a cow, she, as he states, thrust the point of one of her horns into the inner side of the right orbit, rupturing the sclerotic to a considerable extent. Immediate blindness ensued. This injury was followed shortly by severe pain in the eye and about the brow. Two days after he went to some hospital in New York, where he was told that he would never recover any sight in it, but was advised to remain there two or three weeks for treatment. This advice he declined, at the suggestion of a companion, who remarked that "the Doctors would not make liars of themselves, and may be they would do something to his eye so that he should not see." For two weeks he kept his bed. The pain in and about the eye continued some six weeks. A wet compress constituted the only treatment. At the end of this time he could distinguish light and dark outlines, and vision afterwards gradually improved. The vision of the left eye also improved since the injury to the right, and with it he can now count fingers on a dark back ground at a distance of six feet.

In the left eye the conjunctiva is healthy; the tension is slightly diminished; the cornea is clear; the pupil contracts very little under the influence of light, and dilates imperfectly under atropia; it is not quite circular, but no synechiæ are apparent, otherwise the iris appears normal. The lens is opaque, showing radiated striation, apparently somewhat shrunken, and slightly movable. On or in the anterior capsule are three or four white, round bodies, about half the diameter of the head of a medium sized pin, separated from the opaque portion of the lens by a thin layer of a transparent medium, and casting on it a well defined shadow with oblique light.

In right eye the conjunctiva is healthy. The cornea shows a very slight haziness

with oblique light, perhaps only because of the dark back ground. The lens is gone, and every vestige of the iris.

There is a slight cicatrix, about half an inch long, at the upper and inner edge of the sclerotic, about half a line distant from the circumference of the cornea and nearly concentric with it; from near the centre of this cicatrix, another, more marked, runs backward for about a quarter of an inch.

With the ophthalmoscope there are a few floating shreds seen in the vitreous on quick movement of the eye. The whole fundus is distinctly seen. The outline of the optic disc is not quite distinct, nearly the color of the surrounding fundus, and encircled by an incompletely atrophied, irregular zone, a little broader at its outer side, and about one-third the diameter of the disc in width. The retinal vessels are normal. The epithelial layer of the choroid contains very little pigment (he has reddish hair and beard), the pigment of its stroma is also of rather small amount, and it is a little irregularly distributed over the whole fundus, but nowhere in very marked degree. The region of the macula presents nothing special.

With this eye, unaided by a lens, he can count fingers at eighteen inches. With a lens of three and a half inches focal distance, placed one-half inch in front of the cornea, the periphery being covered so as to leave only a central, circular opening, two and a half lines in diameter, and lateral light warded off, he has, however, vision of very nearly one-third, reading No. 50 of Snellen's scale at 16 feet; better than the average result after operation for cataract.

THE TRANSMISSIBILITY OF GLANDERS BETWEEN MAN AND THE HORSE.—M. Guyon has recently presented to the French Academy of Sciences a paper on this subject. Some years ago, a captain of artillery at Algiers died of what was ascertained to be a well-characterized case of glanders. The blood and fluid of the dead body were inoculated on two mares, a horse, and a mule, four animals unfit for service. The disorder was reproduced on the horse, the mule, and on one of the two mares. It is stated that, long after, a military physician, who had helped to dissect the captain's body, gradually declined in health. His fatal illness was long, and accompanied by peculiar symptoms. It was not until the nature of the disorder had become quite patent that the unfortunate physician recollected his having pricked himself very slightly while dissecting the captain's body.—*Lancet.*

Hospital Reports.

MASSACHUSETTS GENERAL HOSPITAL.

Surgical Operations for the week ending February 22d. Reported by Messrs. RUFUS P. LINCOLN and JOSIAH L. HALE, Jr.

[Continued from page 104.]

10. *Tumor of Leg; Amputation through Knee Joint.* Dr. H. J. BIGELOW.—Male, æt. 18. Six months ago, pain called his attention to a small tumor just below the inner condyle of the femur of the right limb. It rapidly increased, accompanied with pain, until, upon entrance, the circumference of the limb just below the patella was four inches more than at the same point around the left leg. Flexion and extension of the leg increased the pain. The form of the limb, at the points described, resembled the inflammatory knee joint of scrofulous subjects. The most prominent portion of the tumor was situated in the inferior half of the popliteal space, and the subcutaneous veins in that region were much enlarged. His general health was becoming impaired in consequence of the constant pain and anxiety. An incision was made into the most prominent portion of the growth, and a small section excised. Dr. Bigelow stated that "its appearance in connection with the evidence adduced, left no doubt as to its malignancy." He then performed amputation at the knee joint, with subsequent excision of the patella and articular cartilage of the femur; the advantage of this operation being, as was stated, "a complete removal of the leg below the knee without leaving an extensive cartilaginous surface, and without the danger attendant upon a considerable opening of the muscles of the thigh."

11. *Painful Stump of Arm; Re-amputation.* Dr. H. J. BIGELOW.—Entered Aug. 24th, 1867, with a compound comminuted fracture of the forearm, and two transverse fractures of the humerus. The forearm was amputated just below the neck of the radius. He was discharged Oct. 10th, well. Re-entered Nov. 10th, on account of neuralgia in his stump; the pain was sometimes located anteriorly, and at others posteriorly, but almost constant in the region of the cicatrix. The latter was quite sensitive upon being touched. There was an ulcer of about the size of a dime between the external condyle of the humerus and the olecranon process of the ulna, while the end of the stump was red, swollen and œdematous. The ulcer was healed in a

week after entrance, but the pain remained, although the usual remedies had been used. Dec. 4th, Dr. Bigelow performed re-amputation at the junction of the middle and lower thirds of the arm. There was no recurrence of the pain until the 20th of January, when it returned with unusual severity midway between the head of the humerus and the olecranon (the location of one of the fractures caused by the injuries received on Aug. 24th). Blisters were applied in the vicinity of the pain, and subcutaneous injection of a solution of sulphate of morphia, but with only temporary relief. His general condition was not improving, and, to recuperate, a trip into the country was advised. In a week he returned, stated that he could not live if the pain persisted, and was ready to submit to any treatment that afforded the slightest prospect of relief.

22d. Dr. Bigelow re-amputated the stump at the middle of the upper third of the arm, by first making a flap of the deltoid muscle and the tissues covering it, reflecting it, sawing the bone at the point described, and dividing the remaining soft tissues from within outward after the main vessels had been compressed, by an assistant seizing the posterior flap. Twenty-three vessels were tied and the wound closed by twelve sutures.. Cold water dressing. Dr. Bigelow stated that "the interesting point in this case was the source of the neuralgic pain, which proved to be the musculo-spiral nerve compressed between the united extremities of the fractured humerus; its fibrous tissue plunging, as it were, into the centre of the bone."

12. *Tumor of Breast; Excision.* Dr. H. J. Bigelow.—One year ago a small tumor appeared near the nipple of the left breast, and rapidly increased, accompanied with lancinating pain, until, upon her entrance, it occupied the upper and outer third of the gland, was as large as a hen's egg, firm, and over its apex for a space one inch in circumference, the integument was shining, thin, and of a dark blue color. No enlargement of axillary glands nor retraction of the nipple. The gland was encircled by two semi-lunar incisions, eight inches in length, and dissected up from its base. Wound closed by twelve sutures after seven vessels had been tied.

13. *Varicocele; Treatment by Ligature.*—Dr. H. J. Bigelow.—The spermatic veins of the left side were very much enlarged, and caused him considerable pain and great inconvenience while attending to his business. A suspensory bandage only afforded him partial relief. A straight incision of three inches was made in the integument over the veins, and the fascia dissected up until they were exposed. Two curved needles, each armed with a double ligature, were passed between the vas deferens and the veins, one inch apart, and tied (the lower one an inch above the testicle). An inch of the varicose mass was thus strangulated.

14. *Double Hydrocele; Radical Operation.* Dr. H. J. Bigelow.—Eighteen years ago, was struck upon the front of the scrotum by an iron bar. Had more or less pain in both testicles at intervals, until, five months ago, the scrotum commenced to swell on the left side, and in a short time after on the right side. Both swelling and pain increased, until, upon entrance, the scrotum was of the shape and size of the heart of an ox; the apex dependent. An incision of four inches was made through the integument into the cavity of the tunica vaginalis of the left side, evacuating nine ounces of serum. Another of two inches was made between the right border of the wound of the integument and the tunica vaginalis, into the cavity of the tunica vaginalis of the right side, evacuating four ounces of serum. It was stated by Dr. Bigelow that "the operation by incision was effective, but sometimes produced sloughing by an excess of inflammation. The operation by seton and injection sometimes failed to produce the desired result. A perfectly safe and uniformly effective operation for hydrocele, was yet a desideratum.

15. *Abscission of Enlarged Tonsils.* Dr. H. J. Bigelow.

16. *Excision of small encysted Tumor of Eyelid.* Dr. H. J. Bigelow.

17. *Nævus.* Dr. H. J. Bigelow. Female, æt. 8. This was a congenital, subcutaneous, erectile tumor which had increased with the growth of the child. It was situated over the left infra spinous fossa, its outline slightly oval, and measured three inches in its long diameter. A semi-lunar incision was made through the integument at the limits of the tumor and the latter carefully dissected out, laying bare the muscle beneath. But three vessels were tied, and the flaps secured in the usual way.

18. *Scrofulous Lymphatic Glands.* Dr. H. J. Bigelow.—Female, aged 20. For the past ten years she had had enlarged glands in the submaxillary region. By a steady growth, two, one above the other, became as large as hickory nuts. These were removed through a vertical incision two inches long.

BOSTON CITY HOSPITAL.

Reported by M. F. Gavin, M.D.

(Service of Dr. Williams.)

Case I.—*Choroiditis, with Separation of the Retina, Right Eye; Atrophy of the Optic Disc, Left Eye, coming on during Pregnancy.*—Sarah M., married, born in Ireland, aged 36 years, medium height, dark complexion, rather anæmic, mother of five children, two living and healthy, three of them stillborn. Three years since, soon after becoming pregnant, sight began to fail both eyes; at the beginning of the 7th month was totally blind. At that time had partial loss of muscular power in the lower extremities. Previous to that time sight good; never had any trouble with eyes. Two weeks after loss of sight, was prematurely delivered of a stillborn child. For about one month previous to delivery, had very severe neuralgic pains in the region of the orbits. Very soon after delivery, vision began to return slowly; at the end of weeks could distinguish light. There was no longer any pain in or about the eyes. Vision in left eye has grown slowly better, except during the period of gestation (three times pregnant, each time prematurely delivered of stillborn child), when sight grows worse. Has never had any cerebral trouble; intellect bright, memory good. Motive and sensitive powers good. At present attends to the management of her own household. General appearance of eyes good; no atrophy or increased tension; irides and lenses healthy. Oblique illumination reveals no changes in the media. Examination with opthalmoscope: right eye, very extensive separation of retina, which appears, however, as if pushed forward by effusion of lymph behind it, and not by mere serous fluid; general appearance of fundus as a pale yellowish reflex; left eye, evidently atrophy of the nerve and diminished calibre of vessels, but otherwise healthy. Tonic treatment was recommended.

Case II.—*Catarrhal Ophthalmia, with Sloughing of the Conjunctiva, Right Eye; Recovery.*—Daniel C—, aged 22 years, single, born in Boston. Always healthy; accustomed to much outdoor work. Never subject to trouble with eyes. Dates beginning of present trouble back four weeks, when he was exposed to cold followed by circumorbital pain, intolerance of light, and a highly congested state of vessels of conjunctiva, right eye. At that time was treated by an old woman, who applied bread and water poultice to the eye, and afterwards put "eye wash" into the eye, which he states caused the appearance of a "scale" on the eye. No improvement followed from this treatment. Has never had any powder blown into the eye, or caustic applied. No trouble with left eye. When patient presented himself for examination, right eye was closely padded with bandages. Conjunctiva deep red color, of a velvety aspect; vessels greatly enlarged; no chemosis; large oblong-shaped slough; whitish-gray appearance just below and to the inside of the pupil, in the ocular conjunctiva; similar sized slough on the opposing palpebral conjunctiva: cornea clear, no abrasion or ulceration; iris looks well; pupil dilated from the absence of light. *Free from pain.* Lids healthy. Profuse muco-purulent discharge from the eye. Patient was directed to use a solution of sulphate of zinc (2 gr. to ʒi.), and the upper lid to be touched with crayon of sulphate of copper twice a week. The slough slowly separated, leaving a cicatrix hardly visible, with no inversion of the lower lid; the intolerance of light grew less, and at the end of four weeks patient was well. No adhesion between opposing surfaces of conjunctiva took place; movement of globe, perfect.

This case is chiefly of interest as showing the large loss of conjunctiva, without subsequent deformity and escharotic effects of the "eye wash" that charlatans use.

Case III.—*Inherited Syphilitic Keratitis, Right Eye.*—John T., aged 23 years, single, born in New York. Has had most diseases liable to childhood, otherwise health good. General appearance of debility, which is, perhaps, owing to a recent attack of smallpox. Has never had syphilis or rheumatism. Well marked alopecia. Two years ago had necrosis of the upper part of shaft of right tibia. Father and mother healthy; two brothers of delicate constitution, but never had any trouble with their eyes. Had an attack of smallpox when a child, and second attack in January last at City Hospital, when he was confined three weeks. When convalescent, trouble began in right eye, with very severe pain in and around the orbit, great intolerance of light and impaired vision. After leaving Hospital eye became worse, preventing sleep. Two weeks after his discharge from Hospital, and all this time suffering with disease in the right eye, he returned as an *out-patient*, when he presented the following appearance: great intolerance of light, conjunctiva free from injection, cornea throughout its whole extent shows a ground-glass appearance, disseminated interstitial opacity,

with slight hemorrhagic spots in portion. Pupil has a tendency to contract, but dilates under atropia; iris slightly changed in color, of a dull aspect. The vessels of the sclerotic much enlarged, of purplish hue; some traces of softening in cornea. The central and lateral incisors show the well marked crescentic notch. A solution of atropia (2 grs. to ℥iv.) has been used to keep the pupil widely dilated. No other treatment has been used.

The patient is still under treatment, showing marked improvement in the disease. As yet, no symptoms of the disease has shown itself in the left eye.

Case IV.—*Inherited Syphilitic Keratitis, Left Eye.*—Henry P., aged 19 years, single, born in Boston. Health generally good. History reveals no tendency to rheumatism, nor does it show any traces of syphilitic disease, acquired or inherited. Parents, brothers and sisters, healthy; has never had any trouble with eyes. Disease began six weeks since, following exposure, with great intolerance of light, dimness of vision, congestion of the vessels of the cornea, but no pain at any time except when he attempts to use the eye for some length of time. Dimness of vision steadily grew worse for four weeks; since then, for the past two weeks, has grown some better. Patient presented himself for treatment at City Hospital two weeks after beginning of attack—four weeks since—when he presented the following appearance: Left eye—vessels of the conjunctiva healthy, cornea covered throughout its lower half with diffused opacity, apparently not in the superficial layer but in the cornea proper; the vessels of the sclerotic injected, and of a pinkish hue; iris dull color, pupil contracted. Vision good for a short time. The central incisors present the peculiar crescentic notch, first pointed out in the London Ophthalmic Hospital Reports by Mr. Jonathan Hutchinson, as characteristic of inherited syphilitic keratitis. At the end of six weeks the right eye began to show incipient symptoms of a similar attack. As a rule, this disease attacks the second eye about the time the first begins to improve. The pupil was kept under the influence of atropia, and a mild collyrium of borax and camphor given. No other treatment was used. The patient has done very well.

The graduating class of the Missouri Medical College, at St. Louis, on the 29th ult., numbered twenty-five. At the St. Louis Medical College, the number was forty-seven.

Bibliographical Notices.

An Inquiry into the Influence upon Health of Anthracite Coal when used as Fuel for Warming Dwelling Houses. With some Remarks upon Special Evaporating Apparatus. By George Derby, M.D., Surgeon to the Boston City Hospital, Editor of State Registration Reports, Late Bvt. Lt. Col., and Surgeon U. S. Vols. Boston: A. Williams & Co. Duodecimo. pp. 46.

It has been the almost universal belief that in buildings warmed by hot air, the purity and pleasantness of the atmosphere were in direct proportion to the amount of moisture it contained, and that the unpleasant sensations experienced in rooms heated by the common furnaces burning anthracite coal, were owing to the circumstance, that the air coming in contact with iron at a high temperature, was in some mysterious way altered in composition and deprived of the moisture necessary to health; and that the superiority of a steam or hot water apparatus was that it furnished air, which was never heated beyond 212°, and thus retained its normal constituents. In this book, Dr. Derby has published an account of a series of experiments, undertaken for the purpose of showing the fallacy of this theory, and he proves conclusively that it is without foundation. The experiments were conducted during some of the coldest weather of this winter. Seven dry and wet bulb hygrometers were placed in as many different buildings, warmed by various methods: steam, hot water, furnaces burning anthracite coal, one burning wood, and a room warmed by an open grate, burning anthracite. Dr. Derby has given us, in a table, the daily observations of each instrument, and the results obtained are very interesting. Contrary to the general impression, the soft agreeable air in the library of the Athenæum, warmed by contact with pipes filled with hot water, was found to be the driest, while the greatest amount of moisture was found in a dwelling heated by an anthracite furnace, without evaporating apparatus. After giving some reasons for the varying amount of moisture in the buildings in which the experiments were conducted, Dr. Derby comes to the conclusion that "Iron heated to any point possible in our furnaces has no power to abstract moisture from the air," and "If the air of a room warmed to 65° or 68° by hot water pipes is pleasant, and the air of a room warmed to

65° or 68° by an anthracite fire is unpleasant, in both cases no artificial evaporation being employed, the difference is not in the simple dryness of the air and must be in something else." Dr. Derby then proceeds to show the real cause of the difference in the quality of the heated air furnished by the various kinds of apparatus in general use. He proves that this difference depends entirely upon the peculiarities of their construction. In the ordinary anthracite furnace, the air is heated by coming in direct contact with the iron pot containing the fuel. These furnaces are constructed with numerous joints, which it is impossible to make perfectly tight, each one of these serving as a passage by which the deleterious gases arising from the combustion of the fuel escape into our houses; while in the other kinds of furnaces, the air is heated by contact with pipes filled with hot water or steam, there being no possibility of its contamination by the fuel; and it is the absence of these gases, and not the presence of moisture, which renders it so agreeable. The community are certainly indebted to Dr. Derby for the light he has thrown upon this subject, a subject in which we are all interested, and concerning which there has been such a general misapprehension. Efforts have hitherto been directed towards increasing the evaporating power of our furnaces as the great remedy for impure air. Of course it has been recognized in a general way, that the gases from the furnace would occasionally escape; but Dr. Derby has the credit of showing, that, as our furnaces are now constructed, these gases are always present in a greater or less degree in our houses, and that the only way of improving them is to decrease the number of joints as much as possible, and to render those that are unavoidable, air tight. For further information we must refer the reader to the book itself, which we recommend to every one interested in this subject. U.

Hufeland's Art of Prolonging Life. Edited by Erasmus Wilson, F.R.S., Author of "A System of Human Anatomy," "Diseases of the Skin," &c. From the last London Edition. Philadelphia: Lindsay & Blakiston. 1867.

That Dr. Wilson should consider a book worthy of bearing his name as Editor on its title page, is a sufficient guarantee of its worth. The Editor says in his Preface, "The 'Art of Prolonging Life,' by Christopher William Hufeland, a philosophic physician and professor of Medicine in the University of Jena, is a work enjoying a deserved popularity in Germany, where it has gone through several editions." He "has selected the translation of 1794, with its pure and classic language, for the present volume, in preference to a new translation from a late German edition." The version chosen, Dr. Wilson judges to be "the production of the learned author's own pen."

Scarcely more remains for us than to give a brief statement of the general arrangement of the work. Part the First occupies about half the book, and contains a review of the history of the science of prolonging life from the time of the Egyptians up to the period when Dr. Hufeland wrote; an inquiry into the nature of the vital power, and the duration of life in general; remarks upon the duration of the life of plants, of animals, and of man; the essential definition of human life; signs of long life in individuals; examination of various methods for prolonging life in vogue in Hufeland's day; etc. etc. In this Part, although there must necessarily occur now and then ideas, among those held by the author, which have, since his time, been modified or laid aside, we have found much that is entertaining and instructive. We make only two extracts.

In Egypt, he says, it was believed "that life could be prolonged by the continued use of emetics and sudorifics. It was, therefore, a general custom to take, at least, two emetics every month; and instead of saying, How do you find yourself? one asked another, How do you perspire?"

It is well for both our scholars and men of leisure to be reminded, that among the Greeks "the greatest philosophers and men of learning never forgot that the body and the soul ought to be exercised in the same proportion."

Part the Second is upon the "Means which shorten Life;" Part the Third—which concludes the book—on the "Means which prolong Life." To this portion of the work, the words of the Editor are especially applicable, that its perusal will dissipate any feeling which might be entertained "of a necessity for bringing the matter up to the present line of march." P.

Papers from the "American Beaver." By W. W. Ely, M.D., Rochester, N. Y. Philadelphia: Lippincott & Co. 1868.

These papers contain a very complete anatomical description of this great Rodent, and are taken from the larger work on the natural history and habits of the beaver, by

the same author. They are illustrated with excellent lithographic views of the whole skeleton, and the bones of the skull and face; and with wood-cuts of some of the peculiar organs of the animal. The American and European varieties are carefully compared, and differences noted. Altogether, the work is a valuable and pleasing contribution to the Natural History of our country. *

Medical and Surgical Journal.

Boston: Thursday, March 26, 1868.

THE BASIS OF A MEDICAL EDUCATION.

In a former number of the Journal,* alluding to the present position of the Medical Profession, we remarked, that the one great way to recover the authoritative position which our fathers held in medicine, was to "steadily raise the standard of medical education." In advocating reform in the present mode of studying medicine, we must look first at the basis of general training on which our professional education rests. Formerly the ordinary undergraduate *curriculum* of our Colleges was the sole mode of preparing men to begin the study of medicine. It is quite different now, as we see readily by two pamphlets which lie on our table. The First is, the "Third Annual Catalogue and Programme of the Massachusetts Institute of Technology;" the second, "The First General Announcement of the Cornell University."

The Institute of Technology professes to teach the application of science to the useful arts, embracing, in its course of instruction, those natural sciences, which are useful to the practical physician in the broader relations of collateral learning, as well as in their direct bearing on his professional work—and among its branches of instruction, we would instance particularly, Practical Chemistry, Mathematics, Physics and Natural Science, and the Modern Languages.

The Cornell University has sprung into existence as the result of the munificent bequest of Ezra Cornell, combined with the aid furnished by Congress to found Agricultural Colleges. Its aims are to furnish the most practical instruction in Agriculture, the Mechanic Arts, History and the Modern and Ancient Languages.

This is not the place in which to discuss the general expediency of shortening the Classical Course in our Colleges, in order to give more room to scientific studies and the modern languages. The merits of the old and the new systems of education have been discussed repeatedly in England as well as in this country, and by abler pens than ours. We may only remark, in passing, that these discussions and the obvious tendency of the public mind have already modified the *curriculum* of our older Universities, and will do so yet more in future.

The question which concerns us is, how far these changes in education are applicable to the medical student before he begins his professional studies. What has he to learn, and what to unlearn, to make himself most useful in his future career? Is it wiser for him to spend his earlier years in acquiring the tongues and the history of the past, or, to train his mind in sciences of comparatively modern growth?

No one, who has been familiar, as a teacher, with successive classes of medical students as they pass through our Colleges, year after year, can doubt the necessity for, and the value of a preliminary education, to train their minds, and to fit them for what they are about to learn. The most marked difference, as to facility of acquiring knowledge and drawing deductions therefrom, distinguishes those who have, from those who have not had a Collegiate education. Into the minds of older men, whose brains have long lain fallow, facts enter slowly, and results are worked out with toil and delay. Memory is untrained, reasoning un-exercised; and the perceptive faculties alone are on a par with the well drilled thinking organs of the College-bred student. And the reflection has often forced itself upon us, that in the over-crowded state of our profession, it were wiser for such students to have remained first-rate agriculturists or mechanics, than to have attempted, at so late a period, to study a science for which their previous mode of life has no

* Editorial, Feb. 27th.

more fitted their minds, than their habit of manual labor has trained their hands to lay down the plough and take up the scalpel. Exceptions exist, of course; great minds appear from among this class; but such will always push their way to the surface through all obstacles.

The advantages of previous education having been admitted, the next point is, as to what education is the most useful to the medical student. A certain amount of familiarity with the Latin language is necessary to the understanding of technical terms in medicine; but far less than formerly. A limited knowledge in Greek is essential to the man of science. Beyond this, the dead languages are not necessary to the practitioner of medicine. If many years are consumed in acquiring them, the only benefit derived is in the mental training this study affords, or the key they furnish to the modern languages of Latin origin.

On the other hand, the modern languages of civilized Europe are of vast importance to the physician. French, as the universal language of science; German, as the key to unlock an incalculable amount of cotemporaneous research and knowledge in the more abstruse, as well as the practical parts of medicine. Both these languages, also, in our own country, are in constant request in practice; and the ability to speak, as well as to read them, opens the road to large classes of practice. Hippocrates and Galen deal with abstractions more than with science; Trousseau and Virchow with matters of daily application and use. And we think no busy practitioner of our time would hesitate between giving up his Latin, and his French or German, if he could have but one. We shall pursue the subject in a future article.

We have received from a medical correspondent a long article from a daily paper, giving an account of the retention in and expulsion from the human stomach of a living crab. Our correspondent has taken pains to show the folly of this story in the same newspaper, quoting Dalton and Flint, and finally demonstrating that the portions of crab ejected were made up of apple seeds and lumbricoides. We have not space to quote the article at length. It is the oft-told story of living animals in the stomach, unassailed by the gastric juice, that solvent so potent to destroy all ingesta but entozoa.

We are glad to learn from the First Annual Report of its Trustees, that the Peabody Museum of American Archæology and Ethnology, recently endowed at Cambridge, is making good progress towards the formation of a valuable collection of specimens, under the energetic oversight of its curator, Dr. Jeffries Wyman.

The collection of crania is already large. Numerous shell heaps in Florida and elsewhere have been explored by Dr. Wyman. Means have been taken to get casts and duplicates from Europe; and a special messenger has been despatched to Central America. In a few years we hope to see the Peabody Museum taking rank beside the Museum of Zoölogy, and adding another great attraction to those which Harvard already possesses as a scientific and literary centre.

Simple Form of Ophthalmoscope. *To the Editor, &c.*—At the request of a medical friend, I call the attention of your readers to a very simple form of ophthalmoscope, which I have several times improvised when away from home and unexpectedly needing my instrument. Go into a tin shop, and with a punch about the size of the ophthalmoscope mirror cut a circular piece of polished tin. With the stroke that cuts the disc it is *usually* made sufficiently concave for the proper focus. This, however, can be altered as may be necessary. The instrument is completed by making, with another small punch, the little perforation in the centre. With such an instrument I have often made a satisfactory examination, and with the addition of a pocket lens the vessels, optic papilla, macula lutea, &c. are clearly defined. So with a bit of nicely polished tin, two punches and a hammer, an instrument is made in a minute, which in an emergency answers a very good purpose. Students can thus avail themselves of the means for practice in such examinations without cost.

Yours truly,
William Warren Greene.
Ann Arbor, Mich., March 17, 1868.

Dr. G. is fortunate in being able to see the macula lutea clearly defined with his

instrument. Most ophthalmoscopists cannot do so with any, in the normal state.

O. F. W.

American Medical Association.—The Nineteenth Annual Meeting of the American Medical Association will be held in Washington, on Tuesday, May 5th, 1868, at 11 o'clock, A.M.

The following Committees are expected to report:—On Ophthalmology, Dr. Jos. S. Hildreth, Illinois, Chairman. On Cultivation of the Cinchona Tree, Dr. J. M. Toner, D. C., Chairman. On Surgical Diseases of Women, Dr. Theophilus Parvin, Ind., Chairman. On Rank of Medical Men in the Navy, Dr. N. S. Davis, Ill., Chairman. On Insanity, Dr. C. A. Lee, N. Y., Chairman. On American Medical Necrology, Dr. C. C. Cox, Md., Chairman. On Leakage of Gas-pipes, Dr. J. C. Draper, N. Y., Chairman. On Medical Ethics, —— ——, Chairman. On Plan of Organization, Dr. C. C. Cox, Md., Chairman. On Provision for the Insane, Dr. C. A. Lee, N. Y., Chairman. On the Climatology and Epidemics of Maine, Dr. J. C. Weston; of New Hampshire, Dr. P. A. Stackpole; Vermont, Dr. Henry Janes; Massachusetts, Dr. Alfred C. Garratt; Rhode Island, Dr. C. W. Parsons; Connecticut, Dr. E. K. Hunt; New York, Dr. W. F. Thoms; New Jersey, Dr. Ezra M. Hunt; Pennsylvania, Dr. D. F. Condie; Maryland, Dr. O. S. Mahon; Georgia, Dr. Juriah Harriss; Missouri, Dr. Geo. Engleman; Alabama, Dr. R. Miller; Texas, Dr. T. J. Heard; Illinois, Dr. R. C. Hamil; Indiana, Dr. J. F. Hibberd; District of Columbia, Dr. T. Antisell; Iowa, Dr. J. W. H. Baker; Michigan, Dr. Abm. Sager; Ohio, Dr. J. W. Russell; California, Dr. F. W. Hatch; Tennessee, Dr. Joseph Jones; West Virginia, Dr. E. A. Hildreth; Minnesota, Dr. Samuel Willey. On Clinical Thermometry in Diphtheria, Dr. Jos. G. Richardson, N. Y., Chairman. On the Treatment of Disease by Atomized Substances, Dr. A. G. Field, Iowa, Chairman. On the Ligation of Arteries, Dr. Benj. Howard, N. Y., Chairman. On the Treatment of Club-Foot without Tenotomy, Dr. L. A. Sayre, N. Y., Chairman. On the Radical Cure of Hernia, Dr. G. C. Blackman, Ohio, Chairman. On Operations for Hare-Lip, Dr. Hammer, Mo., Chairman. On Errors of Diagnosis in Abdominal Tumors, Dr. G. C. E. Weber, Ohio, Chairman. On Prize Essays, Dr. Chas. Woodward, Ohio, Chairman. On Medical Education, Dr. A. B. Palmer, Mich., Chairman. On Medical Literature, Dr. Geo. Mendenhall, Ohio, Chairman.

Secretaries of all medical organizations are requested to forward lists of their Delegates as soon as elected, to the Permanent Secretary.

Wm. B. Atkinson,
Permanent Secretary,
S. W. Cor. Broad and Pine Sts.
Philadelphia.

Died,—suddenly, at Ellicottville, N. Y., on the 12th inst., Augustus Willard, M.D., of Green, Chenango, N. Y., aged 68 years.

Dr. W. was the eldest son of Samuel Willard, M.D., who graduated at Harvard College in 1787, and resided at Stafford, Ct. The deceased was born in 1800. He received a good school and academic education, and in 1821 entered the office of Dr. Charles Josslyn, of Greene, with whom, and the professors of Harvard Medical College, he completed his apprenticeship. In 1823 he graduated at the above named Medical College, and among some forty graduates, received the prize for the best medical thesis of the class. In 1824, he located in the village of Greene, where his sterling intellectual powers, with his strong and undivided application to his professional duties, soon gave him prominence among his professional brethren, and inspired the confidence of the whole community. Through a long life he has fully justified the confidence reposed in him as an honest, upright and skilful physician; and in his professional associations the County, State and National organizations have felt the influence of his talents and his ardent devotion to their interests.

Died,—In this city, on Saturday, March 21, Hon. Henry H. Childs, M.D., of Pittsfield, aged 84. Dr. Childs was the founder of the Berkshire Medical College, of which he has always been the president, and at one time held the office of Lieutenant-Governor of this Commonwealth. He has long been one of the leaders in the profession in the western part of the State, and many will miss the generous hospitality of his Berkshire home.

Hartford Retreat for the Insane.—The Retreat is to be greatly improved during the coming season. The celebrated architects, Vaux, Withers & Co., of New York, have been engaged since last fall in preparing plans and specifications for the proposed improvements, and their plans have been accepted. They contemplate a complete re-modelling of the interior of the present

buildings, and ultimately, though not this season, an enlargement of the buildings by the erection of wings. The apartments in the present buildings are small and low, and it is the design to enlarge and raise them in order to provide suitable accommodations for the better class of patients, as the new asylum at Middletown will take all the pauper patients. The entire cost of the improvements to be made this season will be about $100,000.—*Ct. Courant.*

Bromide of Potassium in Asthma.—Dr. J. D. Palmer, of Monticello, Florida, writes as follows to the editor of the Richmond Medical Journal:

"A case of distressing asthma, of seventeen years' standing, in which the paroxysms occurred nearly every night, with occasional intervals of a week, came under my notice about four months ago. The patient had suffered many things of many physicians, and was nothing bettered, but rather grew worse. I prescribed the bromide of potassium, in twenty grain doses twice a day (as suggested by Dr. Begbie,), and found it capable of exerting the most satisfactory influence over the disease.

"Only two paroxysms have occurred since; and they were produced by unusual exposure, together with the neglect of the remedy. I therefore cordially recommend it."

Digitalis.—Dr. J. D. Brown relates six cases in the *Medical Times and Gazette*, for Jan. 25, 1868, in which he used digitalis in the form of poultice in suppression of urine. He made use of the fresh leaves, dried leaves, or the tincture mixed with flaxseed. All the cases obstinately resisted all other remedies, and it was only after waiting three or four days that the remedy was tried. In each case secretion of urine was obtained. The first case terminated fatally on account of lack of care in the use of the remedy; after a suppression of nine days duration the drug was used, and from 4 A.M. to 10 P.M., the patient passed enough urine to fill "eight ordinary-sized chamber vessels and was still making it." Another case was relieved, but suppression recurring she was neglected by her attendants and died. The other four cases recovered.

"The rules of management must depend on the pulse. I have seen no good results till the pulse fell in number; it matters not from what figure: fall it must before any change occurs. I would strongly advise 60 as a standard from a high number; 40 or 50 from a lower figure—say from 80. Judging from the effects on the circulation, we cannot lose sight of the fact that the arrest of secretion depends on capillary congestion, which in turn might, by pressure, paralyze the nerves. The fact, however, remains that we compel the kidney to resume its functions by diminishing the force of the circulation, lessening the quantity of blood by allowing a much longer interval between each new arrival. Strange, too, it is that in four cases the attack commenced suddenly like a fit of stone, and, in reality, stone came away in each case.

" . . . . It is not supposed that it will succeed in all cases of that mysterious disease; but it is clear that it has a powerful influence over the renal secretions, and if carefully watched, taking the pulse as a guide, no mischief need be feared."

Legislative Regulation of Prostitution.—We see the question of some legislative regulation of prostitution in this city is again before the Assembly. We hope that no such law will be passed, simply because all such enactments tend to increase the very evil against which they are directed. Undoubtedly in matters of morals, the public will not submit to any legislative interference. It only leads to greater desire to evade the law. If all prostitutes could be brought under the regulations, then might some law be advisable. But this is just the trouble, While a few are licensed and restrained, a much greater number find ample opportunity to ply their trade in such a manner as to avoid arrest.

In the number of the *Archives Générales* for December last is a lengthy review of the Paris police regulations in regard to this matter. It shows that while the regulations have not been oppressive, and the number of prostitutes has greatly increased in a period of years, the number of registered *filles publiques* and recognized houses of prostitution has constantly decreased. There are far fewer now than ten years ago, while the size of the city has naturally increased. The registered women now are probably about one-tenth of the whole number. These unregistered ones, even throwing out of account their greater number, are more likely to be diseased. That the same obtains in this country we know from observation of those admitted into the workhouses in this city. The worst cases of disease were found among the women not regular inmates of brothels.—*N. Y. Med. Gazette.*

Selections and Medical Items.

Fractured Patella treated by Malgaigne's Hooks.—In the *Medical Times & Gazette* an account of two cases of transverse fracture of the patella treated by this method is given. The writer maintains that, contrary to the opinion of the majority of surgeons in the United Kingdom, bony union of the patella is obtained after transverse fracture, provided only the surfaces of bone be kept in apposition. The ordinary methods of treatment do not accomplish this. Mr. Gulliver, in his treatise on transverse fracture of the patella, concludes that the reparative tissue is thrown out by the fractured surfaces. Malgaigne, many years before, had observed after death in a case of this fracture that bone had been formed by the fragments, showing an attempt at osseous union. He invented the "hooks," and used them with great success. In the hands of others this treatment failed, on account of improper selection of cases. The hooks should be applied to moderately stout people, but not to the very obese, and they should be put in at once, if at all, before much effusion has occurred into the knee joint. The two cases given show the value of this treatment.

The first case, a woman, aged 46, was admitted to King's College Hospital April 2, 1866, under the care of Mr. Partridge, directly after the accident. The fracture was nearly in the middle of the right patella, transverse, the fragments separated about ¾ of an inch, no effusion into the joint. Malgaigne's hooks were immediately applied, bringing the fragments into close apposition. The limb was placed on a long straight splint, and flexed somewhat on the trunk. There was little pain, no swelling of the knee and no irritation about the wounds made by the hooks in the skin. These were removed May 15, and the fragments were found to have united by bone. The patient was discharged. Two months after, no trace of fracture could be detected, and the woman said "she could walk about as well as ever."

The second case, a man, aged 36, was admitted to the Hospital directly, also under Mr. Partridge's care. There was transverse fracture of right patella near its upper margin. The fragments were separated two fingers breadth. There was little effusion. The left patella had been fractured six years previously, and the fragments were four inches apart. It had not been treated by the "hooks." The right patella was treated as in the first case. Five weeks after, at the time the report was made, there had been no irritation caused by the apparatus, nor much effusion into the joint, and there was apparent bony union, but the hooks had not been removed, as it was considered advisable to retain them in place for six weeks.

Heart Pulsations independent of Nervous System.—It would seem, from a paper recently published by Herr. Schenck, that in the embryo the pulsation of the heart is quite independent of the nervous system. Herr. Schenck states that when the heart of the chick three days old is removed and maintained at a temperature of about 35°C., it continues to beat. Even when cut to pieces, the separate parts for some time keep up an alternate contraction and relaxation. These portions, when placed under the miscroscope, do not appear to possess even the most rudimentary traces of nervous ganglia. (!)—*Med. T. & G.*

Dr. Edward S. Dunster, of New York, has been appointed Professor of Obstetrics in the Medical Department of the University of Vermont, at Burlington.

MEDICAL DIARY OF THE WEEK.

Monday, 8, A.M., Massachusetts General Hospital, Med. Clinic; 9, A.M., Medical Lecture. 9, A.M., City Hospital, Ophthalmic Clinic.

Tuesday, 9, A.M., City Hospital, Medical Clinic; 10, A.M., Medical Lecture. 9 to 11, A.M., Boston Dispensary. 10–11, A.M., Massachusetts Eye and Ear Infirmary.

Wednesday, 10 A.M., Massachusetts General Hospital, Surgical Visit. 11 A.M., Operations.

Thursday, 11 A.M., Massachusetts General Hospital, Clinical Surgical Lecture.

Friday, 9, A.M., City Hospital, Ophthalmic Clinic; 10, A.M., Surgical Visit; 11, A.M., Operations. 9 to 11, A.M., Boston Dispensary.

Saturday, 10, A.M., Massachusetts General Hospital, Surgical Visit; 11, A.M., Operations.

A Bulletin of Expected Operations, in both the Hospitals, will be found, weekly, at the office of the Boston Medical and Surgical Journal, and at Messrs. Codman & Shurtleff's, 13 and 15 Tremont Street.

Correction.—In the number of the Journal for Mar. 12th, page 81, on the third line from the bottom of the second column, for "duration of labor" read *duration of pregnancy.*

To Correspondents.—Communications accepted:—Adherent Placenta; Case of Pelvic Cellulitis; On Ingrowing Nail.

Pamphlets Received.—Catalogue of the Officers and Students of the University of Michigan, for 1867-68, with a General Description of the University. Annual Catalogue and Circular of the New England Conservatory of Music, Boston. Tenth Annual Report of the Chicago Charitable Eye and Ear Infirmary.

Marriages.—In Williamstown, Vt., March 6, Charles C. Ellis, M.D., of Forrest, Michigan, to Miss Sue Ann Palmer, of Williamstown.—In Waterbury, Vt., March 5, George C. Washburn, M.D., to Mrs. Charlotte L. Delano, both of Hardwick.

Died,—In Montreal, Canada, Feb. 14th, Archibald Hall, M.D., Professor of Midwifery and Diseases of Women and Children in McGill University, and formerly Editor of the "British American Medical Journal," aged 56.—In Stratford, Ct., March 6, Dr. William T. Shelton, aged 50 years.

Deaths in Boston for the week ending Saturday noon, March 21st, 1868, 79. Males, 38—Females, 41. Accident, 3—anæmia, 1—inflammation of the bowels, 1—congestion of the brain, 2—disease of the brain, 4—inflammation of the brain, 1—bronchitis, 2—cancer, 1—consumption, 12—convulsions, 3—croup, 1—cyanosis, 2—debility, 5—diarrhœa, 1—diphtheria, 1—epilepsy, 1—erysipelas, 2—fever, 1—scarlet fever, 5—typhoid fever, 1—disease of the heart, 5—homicide, 1—intemperance, 2—disease of the kidneys, 1—disease of the liver, 1—inflammation of the lungs, 3—measles, 2—paralysis, 1—premature birth, 1—puerperal disease, 3—scrofula, 1—spina bifida, 1—suicide, 1—tabes mesenterica, 1—unknown, 4—whooping cough, 1.

Under 5 years of age, 35—between 5 and 20 years, 12—between 20 and 40 years, 14—between 40 and 60 years, 13—above 60 years, 5. Born in the United States, 60—Ireland, 11—other places, 8.